# Rhode Island Pilot Project Planning Grant

# INTERIM REPORT

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**State of Rhode Island**
**Department of Human Services**
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# TABLE OF CONTENTS


| | Page Number |
|---|---|
| A. Executive Summary | 3 |
| B. Background and Previous HRSA SPG Accomplishments | 7 |
| B.1. Previous State Efforts to Address the Uninsured | 7 |
| B.2 Involvement of Key Policymakers | 19 |
| B.3 Accomplishments under the State's Prior HRSA SPG | 21 |
| C. Pilot Grant Activities | 25 |
| D. Implementation Status | 28 |
| E. Recommendations to the Federal Government and HRSA | 33 |
| Appendices | |
| 1. Summary of Policy Options | 34 |
| 2. Project Management Matrix | 36 |
| 3. Reports | 40 |

# A. EXECUTIVE SUMMARY

On September 1, 2005, the Health Resources and Services Administration (HRSA) awarded Rhode Island a State Pilot Planning Grant. This Pilot Planning project is being conducted within the Affordable Small Business Insurance Initiative of the Governor's Health Policy Agenda.

This Pilot Planning project flows directly from the State Planning Grant (SPG) that was awarded to the State by HRSA on September 30, 2003. The SPG was used by the State to research the growing rate of uninsurance in the State to assess which populations/segments were at risk and to investigate possible approaches to address the problem within a Rhode Island context. This effort also took into account Rhode Island's demonstrably successful Medicaid and State Children's Health Insurance Program (SCHIP) expansions under RIte Care and the State's premium assistance program, RIte Share.

**Phase 1: Design & Development of the 2006 Reform Proposal & Legislative Agenda**
Between September 2005 and July, 2006, the Affordable Health Insurance project efforts were predominantly focused on developing a reform proposal and legislative agenda which begins to address the erosion in private insurance coverage through incremental strategies focused on the following target population: Low-wage small businesses and high-risk individuals in the direct pay market. A combination of primary and secondary research gathered and analyzed by this project team demonstrated that these populations were the "bleeding edge" of the private insurance crisis in Rhode Island, and most likely to be or shortly become uninsured.

This proposal was informed by the following:

- Consultation with national policy experts: For example Deb Chollet, Enrique Martinez-Vidal, Rick Curtis, Ed Neuchler
- Research/lessons learned from other states' efforts to address these issues: Particular attention was paid to Healthy New York, Dirigo (Maine), and the current Massachusetts reform proposals. The team also looked more generally at Vermont, West Virginia, Maryland, California, New Hampshire and others.
- Internal analysis of the Individual/Direct Pay Market and Small Group Market in Rhode Island, and what was specifically most needed and most practical here
- Consultation with local stakeholders – insurers, chambers, businesses, advocates

**The *initial reform* proposal included the following three key initiatives:**

**a) Affordable Health Plan: WellCare**

- *Create an affordable product, called WellCare.* Mandate that all insurers offer the WellCare product in the small group and individual markets. The Health

Insurance Commissioner, with the help of a newly established WellCare Advisory Committee of purchasers, would establish RFP-like product requirements, as a guideline for insurers. These requirements would enable the product to begin to address the underlying cost of care in Rhode Island, by providing added specificity to the following legislative guidelines:

- Focus on primary care, prevention, and wellness
- Encourage use of least cost, most appropriate settings
- Use of evidence based, quality care
- Active management of the chronically ill population

In addition, the proposed legislation capped the price of the WellCare product at no more than 10% of average Rhode Island wages.

- *Allow small businesses to leverage the purchasing power of the state in buying the WellCare product.* This would be achieved through enhanced regulatory authority over WellCare. For example, the Health Insurance Commissioner would have the authority to approve, disapprove or modify the rates, administrative practices and/or plan features proposed to be offered by the carriers

**b) WellCare Reinsurance Program**

- *Encourage take up of WellCare* through a reinsurance-based subsidy. Focus on those most at risk -- low wage small businesses/workers + individual/direct pay members.
- *Encourage insurer participation* by linking participation in the program to insurer eligibility to participate in the procurement process for the Rhode Island state employee account.
- *Establish the Trust for Rhode Island Health Insurance, to fund this program.* $100 Million in securitized tobacco payments were to be invested for WellCare, providing perpetual annual contributions of $5-7 Million. This Trust was to be supplemented with another $5-10 Million annually through charges on surplus health plan administration and profits.

c) **Consumer Health Care Price Transparency**

- *Requires insurers to provide cost information by facility and procedure:* Proposed legislation specified that any plan sold in Rhode Island with a deductible or other cost sharing must be supported by specific cost information as needed to guide decision-making. Pricing information must be provided for the top 25-50 most frequently performed procedures, for each provider type and/or facility specified.

- *Why it works:* Almost half (44% and growing) of all small group insureds have some form of cost share beyond basic co-pays. Consumers can be an important and effective driver of decision-making that promotes quality, cost effective care. However, today's consumers are ill-prepared for such decision-making – they lack the necessary tools and information to support cost effective choices. In Rhode Island, the cost of care varies substantially by facility – for example, the

cost of an MRI ranges from $1,364 to $450, depending upon the facility where the service was performed. Similarly, the cost of a colonoscopy varies from $1,266 to $487 by facility. By (ultimately) providing end consumers with cost and quality information by procedure AND facility, consumers can play a role in addressing the underlying cost of care in Rhode Island.

***Legislation passed in July 2006 was the culmination of this incremental planning effort, as the following key elements passed into law:***

1. **Affordable Health Plan: WellCare**
   This legislation passed, mostly in the same form as proposed above. As such, the state bargains with insurers to design a product priced 25% below the price of standard small business health plan offerings. The state sets a price – 10% of average RI wages, or $314 per month – and develops RFP-like requirements with a stakeholder group to guide insurers. Insurers respond to RFP with innovative benefit designs and competitive administrative loads. WellCare is ultimately offered as a choice for small businesses through the commercial market.

2. **Reinsurance for Low Wage Businesses**
   This legislation passed, mostly in the same form as proposed above, without the proposed funding source. It provides an incentive for workers at businesses in the lowest quartile of average wages and direct pay enrollees to purchase WellCare. As such, it will provide a further discount of 10 percent – for up to 23,000 low wage RI citizens. The legislation specifically structures this incentive as a reinsurance program, key elements of which are to be specified in regulation promulgated by the Office of the Health Insurance Commissioner. Program implementation is authorized by law, but subject to identification of an alternative funding source during the 2007 legislative session.

3. **Transparency**
   This legislation was significantly revised through the legislative process. What passed in July of 2006 is step one toward the ultimate objective of providing user-friendly, cost and quality information to end consumers by procedure and facility. As such, this legislation requires the insurers to work with the Office of the Health Insurance Commissioner (OHIC) to develop a plan for providing patient access to cost data by March 15, 2007.

**Phase 2: Initial implementation of the 2006 reform legislation, and future planning**

Once the reform legislation passed in July 2006, the Affordable Health Insurance team began to shift its focus toward the following four key efforts:

1. *Implementation of the WellCare Initiative*
   The WellCare product is on a tight legislatively defined timeline – the Advisory Committee needed to be established by July 15th, 2006, the product requirements

document needs to be developed by this committee and submitted to the insurers by November 1st, 2006, and the product needs to be offered in the small group and direct pay markets by June, 2007. Implementation is underway, with the assistance of a benefits consultant – Boston Benefit Partners, who is under contract to facilitate the design process.

2. *Implementation Planning for the WellCare Reinsurance Program*
   As described above, the WellCare reinsurance program passed, unfunded, in July 2006 with a commitment by the legislature to explore additional funding sources this year. As such, short term efforts are focused in two areas: (1) Identifying viable funding sources for an estimated $24 Million subsidy program; (2) More detailed planning for the specific structure of the reinsurance program.

3. *Developing internal consensus around a potential longer-term plan to reach Universal Coverage in Rhode Island.* The Affordable Health Insurance team recognizes that the existing incremental strategies, while they may stem the decline in private insurance, are unlikely to fundamentally reverse the trend. As such, the team is working to design a more comprehensive longer-term strategy, targeting health insurance coverage for all Rhode Islanders. This planning effort has been informed by a detailed assessment of the reform efforts in Vermont, Massachusetts, and Maine, and requires innovative coordination of efforts between the Department of Human Services, Executive Office of Health and Human Services and the Office of the Health Insurance Commissioner

4. *Developing a 2006-07 reform plan & legislative package that links our short term incremental strategies to our longer term plan for Universal Coverage.* The longer term plan toward universal coverage is only a starting point, and one that will likely be continuously refined in the coming year. However, it provides important direction to the short term reform plan and legislative strategies to be proposed for the 2006-07 session. The team is currently developing a range of short term strategy options – ranging from very modest to very aggressive, to move forward this year toward the ultimate objective of Universal Coverage.

# B. BACKGROUND AND PREVIOUS HRSA SPG ACCOMPLISHMENTS

## B.1. Previous State Efforts to Address the Uninsured

The State's previous efforts to address the uninsured are rooted in its history of Medicaid coverage expansions. The State of Rhode Island has approached Medicaid expansions incrementally. In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1)[1] by the U.S. Department of Health and Human Services (HHS) to develop and implement a mandatory Medicaid managed care demonstration program called RIte Care. RIte Care, implemented in August 1994, has had the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

The pursuit of this waiver flowed from enactment in 1993 of § 42-12.3 of the General Laws (G.L.) of Rhode Island. The intent of the Rhode Island General Assembly was explicit, as shown in §42-12.3-2:

> "It is the intent of the general assembly to assure access to the comprehensive health care by providing health insurance to all Rhode Islanders who are uninsured."

Thus, for more than a decade Rhode Island has pursued this intent.

RIte Care was initially designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[2] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

[1] The waiver runs through July 31, 2008.

[2]Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF). FIP is Rhode Island's program for the TANF-eligible population.

RIte Care has been expanded six times, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured

- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured

- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act)

- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

- Effective December 1, 2000, to maximize children in foster care placements from fee-for-service Medicaid to RIte Care

- Effective January 29, 2003, to enroll children with special health care needs into RIte Care including:

    - Blind/disabled children and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)

    - Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children)

    - Children receiving subsidized adoption assistance

The May 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Children's Health Insurance Program, or SCHIP) of the Social Security Act.[3] By Section 1115 SCHIP waiver approval (21-W-00002/1-01)[4], effective January 18, 2001, Section 1931 parents and relative caretakers and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI.

On April 17, 2003, Rhode Island became the first State to be approved by CMS for a separate child health program under SCHIP to cover unborn children with family income

[3] The State did obtain approval on January 5, 1999 to expand SCHIP coverage for children aged 8 to 19 up to 300 percent of the FPL, but this expansion has not been undertaken to due budget constraints.
[4] This waiver, which is now combined administratively with the Medicaid waiver, runs through July 31, 2008.

up to 250 percent of the FPL. This allows the State to provide coverage for pregnant women who are not eligible for Medicaid due to their "unqualified" alien status.

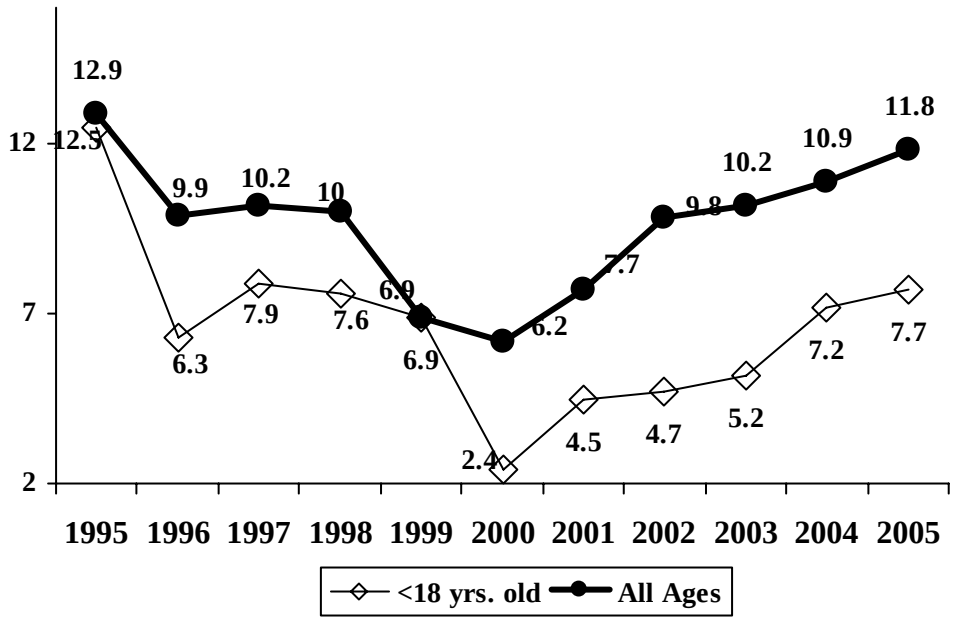
In addition to these covered populations, the RIte Care Health Plans must make coverage available to certain State-funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL
- Children who are uninsured whose household income is in excess of 250 percent of the FPL
- Licensed family child care providers and their children under age 18

RIte Care was demonstrably successful in accomplishing its goals – at times, perhaps, too successful as Figure 1 shows with the sharp drop in the level of uninsurance in the State after the Medicaid expansions.

**Figure 1**

**Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2005**




RIte Care's enrollment grew substantially from 1998 through 2001 as a result of four significant and concurrent events:

- As noted above, the State expanded eligibility to parents and relative caretakers of RIte Care-enrolled children up to 185 percent of the FPL, under Section 1931 of the Social Security Act.

- The State streamlined the RIte Care application process, by creating a short, mail-in application in English and Spanish and eliminating face-to-face interviews for both the initial eligibility determination and for re-determination.

- The State embarked on an ambitious community-based outreach campaign to reach and enroll uninsured children and families.

- The State's commercial insurance market began to deteriorate, marked by sharp increases in premium rates offered to employers, reduced competition as a result of two of the State's commercial insurers (i.e., Harvard Pilgrim and Tufts), and significant hospital and Health Plan losses.

Over the same period of time, RIte Care's enrollment grew by 41 percent – from 74,000 in November 1998 to 104,000 by June 2000. Before that time, RIte Care enrollment had remained relatively stable despite the incremental expansions in coverage for children described earlier. The magnitude of the enrollment growth caused large, unexpected increases in program costs.

While it is still unclear to the State which of these four events contributed most to RIte Care's enrollment growth, it was most likely the combination of all four. It is also unclear how much of RIte Care's growth was due to a shift from private, employer-sponsored insurance (ESI) coverage to public coverage (referred to in the research literature as either "substitution" or "crowd-out"), although to some degree this undoubtedly occurred.

In January 2000, then Governor Lincoln Almond convened a group of Administration staff, legislative leaders, and consumer and business representatives to find a solution to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee (Steering Committee), as the workgroup was called, was jointly chaired by: Christine Ferguson, then Director of the Rhode Island Department of Human Services (DHS); Senator Thomas Izzo, Chair of the Senate Health, Education and Welfare Committee; and Representative Gerard Martineau, House Majority Leader. The Steering Committee was broadly representative of employers, consumers, labor, and the legislative and executive branches of government. Health care providers and insurers were invited to attend meetings and provide testimony to the Steering Committee.

During the next six months, the Steering Committee focused on methods to stabilize the ESI market. Specifically, the Steering Committee examined methods to enable small businesses to maintain ESI by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain ESI. The focus on small employers was due to the

increasing number of businesses with less than 50 workers reporting the most volatile rate increases and the resulting difficulty in retaining and/or obtaining ESI, as well as the vital role these employers play in the State's overall economic health.

Governor Almond signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1 –** Directing DHS to stabilize the RIte Care program by targeting resources to those most in need of coverage–low-wage families without access to affordable coverage, through:
    - Authorizing DHS to establish eligibility requirements for RIte Care to deter substitution (i.e., a waiting period for new applicants who were enrolled in ESI within six months prior to application)
    - Establishing cost-sharing requirements for certain RIte Care-eligible populations to promote both responsible utilization of health care services and development of additional disincentives for substitution
    - Requiring mandatory participation in RIte Share of eligible individuals and families who have access to ESI. RIte Share[5] is the premium assistance program created by the statute to support employees in purchasing or retaining ESI. (This was been implemented under a separate Section 1906 Medicaid State Plan Amendment.)
- **Part 2 –** Reforming the health insurance marketplace to conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, stabilize premiums in the small group market by compressing rate bands, and guarantee issue of a basic health plan
- **Part 3 –** Establishing new financial reserve requirements for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC)

The passage of Part 1 of the Health Reform Rhode Island 2000 represented a significant and important consensus between the Governor and leaders in the General Assembly – RIte Care must be consistent with its original mission to provide coverage to the truly uninsured and migration from ESI to RIte Care should be deterred. The Governor and General Assembly were also clear that if the RIte Care caseload and cost growth are not

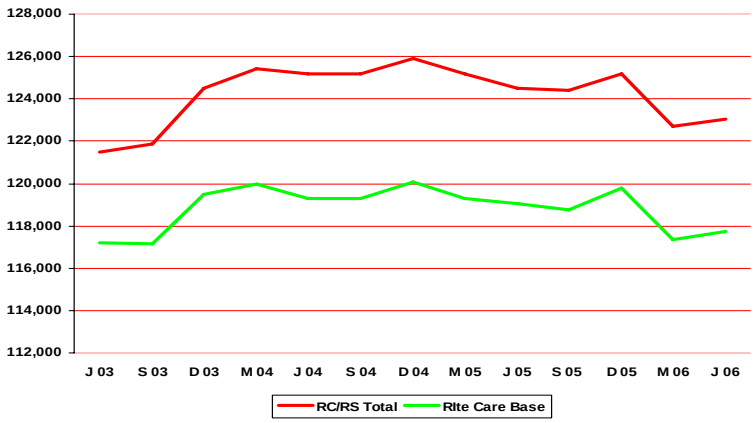
[5] Under RIte Share individuals with access to ESI, irrespective of their being otherwise eligible for Medicaid, must enroll in the employer-sponsored plan. The State and the family share in the cost of the premium (the family's share is set so as not to exceed five percent of family income). RIte Share also covers the costs of co-payments and provides Medicaid-covered services not covered by ESI as wraparound benefits.

controlled by Part 1 of the statute, a roll-back of eligibility expansions currently in place for working families, particularly the Section 1931 expansion implemented in 1998 for parents and relative caretakers whose incomes are above TANF levels, will be considered.

There is no doubt that the reduction in the level of uninsurance shown in Figure 1 was due to RIte Care. As Figure 2 shows, RIte Share has served to stabilize the enrollment in RIte Care, as intended by Health Reform Rhode Island 2000.

**Figure 2**

**RIte Care/RIte Share Enrollment as of June 30, 2006**



Enrollment of both employees and employers in the RIte Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of July 2006, 1,056 employers were approved for participation in RIte Share.

Since February 2001, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. Thus, while plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a "down economy".

In summary, Part 1 of Health Reform Rhode Island 2000 seems to be accomplishing its intended results. In RIte Care, DHS pays Health Plans $450 per month for an average RIte Care family. RIte Share's average monthly contribution to a family's ESI coverage is $338 (approximately one-half of the monthly cost of family coverage in the Rhode Island commercial health insurance market). RIte Share ensures that Medicaid is the insurer of last resort and enables DHS to leverage commercial insurance to offset State dollars.

Table 1 shows the estimated RIte Share savings for SFYs 2001 through SFY 2006. As the table shows, RIte Share savings have increased over time. There have been aggregate Gross RIte Share Savings of $16,194,095 and Net Savings[6] of $14,997,973 since RIte Share began, through SFY 2006. In SFY 2006, the Net Savings per family per month was $184 and the Net Savings per individual per month was $57. As the table shows, these savings are down somewhat from prior years as the cost of ESI has risen

6 This is Gross Savings less the cost of State-paid deductibles, co-payments, coinsurance, and wraparound benefits that are referred to in the aggregate as "Supplemental Benefits".

**Table 1**

**RIte Share Gross and Net Savings**

| | SFY 2001 | SFY 2002 | SFY 2003 | SFY 2004 | SFY 2005 | SFY 2006 |
|---|---|---|---|---|---|---|
| (1) Potential RIte Care Cost | $10,800 | $827,100 | $5,403,600 | $8,859,600 | $9,977,850 | $9,495,000 |
| (2) Gross Savings | $949 | $301,206 | $2,860,069 | $4,073,062 | $4,467,331 | $3,874,303 |
| (3) Supplemental Benefits | $256 | $9,162 | $325,623 | $861,081 | $959,472 | $1,239,009 |
| (4) Net Savings (3-2) | $692 | $292,045 | $2,534,446 | $3,211,981 | $3,507,858 | $2,635,295 |
| (5) Savings per Family Per Month | $40 | $164 | $238 | $207 | $201 | $184 |
| (6) Savings per Individual per Month | $12 | $51 | $74 | $65 | $63 | $57 |

To discourage *crowd-out* (i.e., substituting public coverage for ESI), the State is using a combination of cost-sharing and mandatory enrollment in RIte Share. Since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., $22,530 for a family of three). In November 2001 families received two letters and an official notice about the change. The first monthly bills were sent in December 2001, requiring payment by January 1, 2002. Rhode Island was one of four States increasing enrollee cost-sharing in 2002, with another 11 States expected to do so in 2003[7].

Monthly premium shares are collected in two ways:

[7] Academy Health. *State of the State: Bridging the Health Coverage Gap*, January 2003.

- For RIte Care members, DHS sends a bill and the family pays DHS directly by mailing a check.

- For RIte Share members, DHS deducts the monthly premium share from the amount it reimburses the member for the employee's share of employer coverage.

The monthly family share amount by income level is shown in Table 2[8], comparing the original premium-share amounts to those in effect since August 1, 2002. These premium-share increases were a result of a State law mandating that cost-sharing be raised.

**Table 2**

**RIte Care and RIte Share Monthly Family Premiums**

| Income Level | Monthly Family Premium From 1/1/02 to 7/31/02 | Monthly Family Premium As Of 8/1/02 |
|---|---|---|
| 150%-185% of FPL | $43 | $61 |
| 185%-200% of FPL | $53 | $77 |
| 200%-250% of FPL | $58 | $92 |

On a monthly basis, about 10 percent of all RIte Care/RIte Share families are subject to cost-sharing. Table 3 shows the number of families and individuals, by income level, active in cost-sharing as of July 31, 2006. There were 5,521 RIte Care/RIte Share families (13,714 individuals) active in cost-sharing at the end of July 2006. There were 23,127 RIte Care/RIte Share families *ever* active in cost-sharing through July 2005.

[8] Rhode Island law limits monthly premium payments to no more than five percent of a family's income. Prior to January 1, 2002, enrollees with incomes above 185 percent of the FPL had a choice of paying a portion of their premium each month along with a short schedule of co-payments or paying no premiums and being subject to a longer schedule of co-payments.

**Table 3**

**RIte Care/ RIte Share Families and Individuals Active in Cost-Sharing**

**as of July 31, 2006**

| Income Level | Families | Adults | Children | Total Individuals |
|---|---|---|---|---|
| 150-185% of FPL | 3,575 | 4,389 | 5,934 | 10,323 |
| 185-200% of FPL | 683 | 21 | 1,194 | 1,215 |
| 200-250% of FPL | 1,200 | 51 | 2,009 | 2,060 |
| 250 – 350% of FPL (family child care providers) | 63 | 61 | 55 | 116 |
| **Total** | **5,521** | **4,522** | **9,192** | **13,714** |

Part 2 of Health Reform Rhode Island 2000, small group reform, has also been reasonably effective. The purposes of this reform are described in R.I.G.L. § 27-50-2, and listed below:

1. To enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience
2. To prevent abusive rating practices
3. To prevent segmentation of the health insurance market based upon health risk
4. To spread health risk more broadly
5. To require disclosure of rating practices to purchasers
6. To establish rules regarding renewability of coverage
7. To limit the use of pre-existing condition exclusions
8. To provide for the development of Economy, Standard and Basic health benefit plans to be offered to all employers
9. To improve the overall fairness and efficiency of the small group health insurance market

A market conduct study recently performed by Hinckley, Allen & Tringale confirms that, with a few modest exceptions, this reform effort has been generally successful at achieving these goals: Health insurance is generally available to small employers regardless of health status, there was no evidence of abusive rating practices, rates disparities within small group by group size have been virtually eliminated, and the four to one compression has resulted in health risks being spread more broadly.

Importantly, the examiners also note that "R.I.G.L. § 27-50-2(b) states that Chapter 27-50 is not intended to provide a comprehensive solution to the problem of affordability of healthcare or health insurance." As such, additional legislation would be required to address this broader issue.

This background, while fairly lengthy in its historical description, is important in underscoring that Rhode Island had already implemented what many other States are just now contemplating.

By letter of September 30, 2003, the State of Rhode Island was awarded a $961,156 Health Resources and Services Administration (HRSA) State Planning Grant (SPG). Governor Donald L. Carcieri designated the Rhode Island Department of Human Services (DHS) the lead agency for project grant activities and Tricia Leddy, Administrator of the DHS Center for Child and Family Health, assumed the role of project director for the grant.

The SPG grant allowed the State to focus on a critical issue in Rhode Island: health insurance access and affordability. From 2000 to 2003, the number of uninsured in Rhode Island – two-thirds of them in the workforce – rose a staggering 65 percent. Although this trend is shocking, it is less surprising in light of two other facts:

- The average commercial health insurance premium in Rhode Island *doubled* from 1997 to 2003.

- The share of Rhode Island's population covered by employer-based insurance fell more than seven percent from 2000 to 2003.

As a starting point, it is important to understand that Rhode Island, as noted earlier, already implemented what many States are just now contemplating – significant and comprehensive Medicaid expansion. As such, the State's efforts needed to go beyond traditional Medicaid expansion strategies and, therefore, focus on broader reforms to the employer-based insurance system. This coordinated with certain directives from the Rhode Island General Assembly. DHS was directed to examine other options as well to address the ongoing uninsurance in the State. G.L. 40-8.4, which incorporates the Health Reform Rhode Island 2000 initiatives, also directed DHS, in § 40-8.4-7, to:

> ". . . investigate and develop opportunities for individuals and/or employers to buy into, at the individual's and or employer's expense, one or more programs the

> department may establish under this chapter or chapter 12.3 of title 42 to address uninsurance among Rhode Islanders . . ."

In addition, H 7713 required DHS to:

> ". . . develop a plan for a primary care pilot program for uninsured residents in the state. This program may include enrollee premiums and co-insurance payments that are income-based with premiums and co-insurance subsidized by the state. The pilot program may also include catastrophic or reinsurance coverage provided under the auspices of the state. In designing the program, the director may consider a variety of service delivery and financing models including capitation payments to private physicians, a buy-in program under RIte Care and coverage arrangements purchased from qualified community health centers."

Thus, much of the initial efforts under the SPG grant were directed at fulfilling these legislative directives.

The first challenge for the SPG planning effort was focus: Which populations/which segments of the population were at risk? This grant allowed for a comprehensive review of existing research sources in Rhode Island to answer this question. The key finding from this review was: Small businesses and their employees, most notably those companies with less than 10 employees, have been particularly hard hit by the dramatic rise in health insurance premiums – only 48 percent of employers with fewer than 10 employees offered health insurance, compared with 99.5 percent of employers with 50 or more employees. In addition, the level of uninsurance for relatively young, employed males (i.e., 18 to 34) was highest among the uninsured who were employed.

The second challenge for this planning effort was evaluation: Why were many small businesses no longer offering health insurance to their employees? The evaluation by the Stare found, of course, a major factor was price – with premiums increasing at 10-12 percent per year while general inflation was running at about 3-4 percent. It was not surprising, therefore, that many employers could no longer afford to offer insurance. However, with the help of this grant the State was able to perform a detailed survey of Rhode Island employers on this subject, supported by a more qualitative set of focus groups with small business owners. The results of these two research efforts will be available in late October, and will provide critical guidance and policy direction.

Finally, the State needed to ask the question: What should be done? The SPG grant allowed the State to perform extensive research on the Rhode Island commercial marketplace, to create a common understanding of our starting point as we begin to embark on significant reform. It also allowed Rhode Island to research other States' reform efforts, and learn critical lessons learned regarding policy options, funding strategies, etc.

The final critical component of the State's policy environment prior to the award of the Pilot Project Planning Grant was that in March 2005, Christopher Koller was appointed

as the first Health Insurance Commissioner of Rhode Island. Part of his responsibility in this newly created position was to act as the Health Policy Advisor to the Governor.

**B.2 Involvement of Key Policymakers**

Under Commissioner Koller, a Directors Health Care Group (DHCG) has been established. The vision of this Director's group is that "Rhode Island will have a health system driven by all its residents that focuses on wellness as well as care of the sick."

The mission of the DHCG is as follows[9]: "To drive collaboration among and between state agencies and community, business and other stakeholders to achieve our vision, by focusing on five areas:

1. Make a Habit of Wellness

    - We will create policies that encourage people to adopt healthy lifestyles.

2. Balanced Health Care System

    - When a person seeks medical care, they should have a home base and care should be provided in places where "practice makes perfect."

3. Health Information When You Need It

    - Medical care will be better when a person has electronic access to all their medical information, anywhere, at any time.

4. Make the State a Better Health Care Buyer

    - Improved coordination of the state's large health care purchasing will save the state money and drive change.

5. Increase the Number of Small Business Employees with Health Insurance

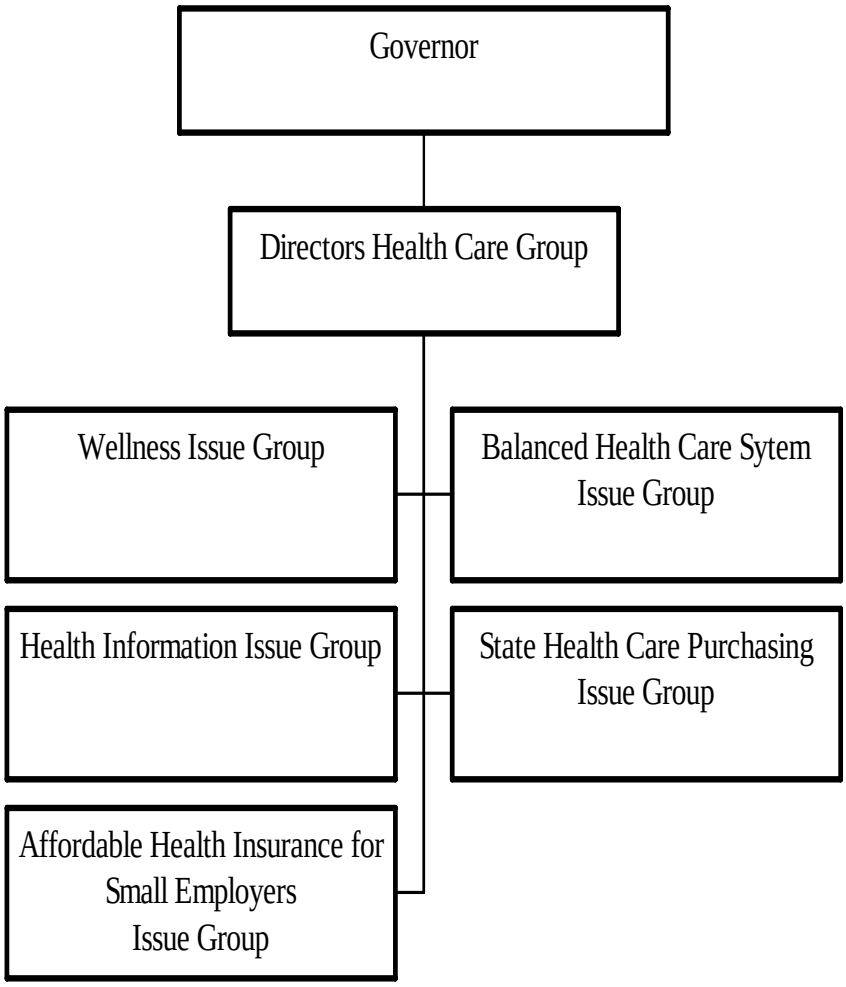
    - The State will find ways to help small businesses get similar health care benefits at similar costs as larger employers.

The DHCG is made up of key leaders from the following State agencies: The Executive Director of the Office of Health and Human Services, Director of Rhode Island Economic Development Corporation, Director of Department of Labor and Training, Director of Department of Health, Director of Department of Administration, and Health Insurance Commissioner (Chair). Figure 3 shows the organizational structure for DHCG.

[9] Directors Health Care Group Charter, 10/05

**Figure 2**

**Directors Health Care Group: Organizational Structure**




Within this broader governance structure, the Affordable Health Insurance for Small Employers Issue Group (AHI) has its own organizational structure.

This issue group has three basic teams[10]. There is a small *Core Implementation Team*, who is critically involved in the day-to-day activities to actively implement the strategies. This team meets once a week and communicates regularly in an effort to "get the job done" quickly and efficiently.

[10] AHI Charter, 08/31/05

There is also a broader internal *Advisory Group*. This group includes individuals from a variety of different functional areas who have valuable expertise or experience related to the workgroups' tasks, but will not actively participate in the day-to-day work. This team meets once a month.

In addition to these two internal teams, a *Small Employer Advisory Group* was created as an informal group of employers interested and engaged in the issue of health insurance affordability to provide valuable context, ideas, and feedback on the State's strategies and tactics.

### B.3 Accomplishments under the State's Prior HRSA SPG

As described above, the majority of the SPG grant was focused on data collection and analysis including the following:

- *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island 1996-2002*, May 2004
- *Do Gaps in Children's Health Coverage Make a Difference?*, September 2004
- *Who Are The Uninsured In Rhode Island? Demographic Trends, Access to Care and Health Status for Under 65 Population*, January 2005
- *Profiles and Trends of the Uninsured in Rhode Island- 2003 Update*, April *2005*
- *Characteristics of Uninsured Rhode Islanders in Three Age Groups*, June 2005

In addition to these reports that were prepared, *Medical Expenditure Panel Survey – Insurance Component* (MEPS-IC) data were analyzed and the Rhode Island Employer Health Survey and employer focus groups were undertaken as activities under the SPG grant.

Based upon the various analyses performed, the State used the H 7713 requirement to report to the Rhode Island General Assembly to frame the discussion of potential solutions to the problems identified. The report[11] proposed to develop a health plan that was responsive to the needs of all stakeholders: employers, employees, insurers, and agents and providers. Specifically, the report delineated the following objectives to address the affordability of health care and reduce the number of uninsured in the State:

[11] Hayward, J.A. and R.A. Lebel. *The Rhode Island Care for Families Act: Report to the General Assembly*, January 2005.

- The populations "at risk of uninsurance" need more choices for coverage. At risk populations include:
    - Working individuals and their dependents whose employers do not offer health care coverage, who are not eligible for their employers' coverage or cannot afford or are struggling to afford coverage

    - Self-employed individuals and dependents who cannot afford or are struggling to afford coverage

    - Unemployed individuals and their dependents who are uninsured and cannot afford or are struggling to afford COBRA or "direct pay" coverage

- Health insurance rates, particularly for small employers, should have reasonable and stable annual trends, as well as minimal year-to-year volatility, resulting in an increased number of employers who offer health insurance to their employees.

- When offered, enrollment in employer-sponsored health insurance should be affordable to all workers, resulting in:

    - An increased number of working Rhode Islanders enrolling in employer-sponsored coverage

    - An increased number of working families switching from RIte Care to RIte Share

The report outlined the following general approach:

- The State should design and assess the feasibility of a plan, with public input, which should be offered to Rhode Island small businesses.

- The health plan should incorporate the flexibility to include features that ensure affordability for employers and employees.

- The State should issue a Request for Proposals for health insurers to offer this plan.

- The State should create a reinsurance program for hospital costs, built around the principle of supplementing the cost of hospital services for all enrollees in the plan.

- The State should build on the lessons-learned from the RIte Care program, in particular, the oversight and monitoring function, which should ensure the appropriate implementation, operation, reporting, and evaluation of the plan in accordance with terms set by the State.

The report delineated the following design principles for the plan:

- Utilize value-based purchasing and "pay for performance" methods to ensure quality, utilizing access and quality standards as well as incentives for quality improvement

- Provide incentives to providers and enrollees to emphasize access to primary and preventive care, as well as management of chronic diseases

- Make the quality and cost of services transparent

- Create a benefit design that encourages rational consumer behavior based on quality and cost considerations

- Incorporate consumer education as well as consumer incentives to promote healthy behaviors

- Incorporate employer support and incentives to promote workplace wellness activities

- Provide affordable access to quality, medically necessary care

- Provide access to a coordinated, accessible organized delivery system that incentivizes enrollees to seek and receive care in the most appropriate and lowest cost setting, incorporating a quality, accessible system of community-based health services and as little as possible reliance on institutional-based services

- Build on evidence-based practice standards for covered services and service delivery models

- Make the plan simple to navigate for enrollees and providers

- Be flexible in design to be able to incorporate new design concepts, such as Health Savings Accounts

Finally, the report delineated the following financing principles:

- Medically necessary services in the lowest-cost setting should be fully insured

    - Services components covered by the premium (i.e., financed by the monthly combined employer/employee premium) should include:

        - The full cost of primary/preventive care, disease management, care management, non-emergency sick care in community-based settings, and patient education

- The full cost of medically necessary specialty and ancillary service (e.g., specialists, imaging, and laboratory) delivered by providers that are both quality-qualified and that are the least costly to the insurer.

- The full cost of medically necessary hospital care at qualified facilities/institutions offering a payment mechanism that emphasizes cost-efficient care.

- Qualified providers who participate in the plan at a higher contractual rate should also be accessible; however, the additional cost beyond the least-cost "allowance" should be borne by the enrollees and should not be part of the "insured" premium (whose costs are passed on to the employer and all employees).

- Employer-paid and employee-paid monthly premiums should assure access to affordable medically necessary care for all members. Members choosing to use higher cost care settings pay the additional cost above the allowable amount.

Appendix 1 summarizes the options considered by the State.

## C. PILOT GRANT ACTIVITIES

At this point, Governor Carcieri has established a specific goal within his Health Policy Agenda: **Rhode Island will improve the affordability of health insurance for the individual and small business insurance market, increasing by 10,000, or 15 percent, the number of small business employees enrolled in employer-sponsored health insurance.** This goal is to be accomplished by facilitating the development of health insurance offerings that create incentives for employers, providers, health plans, and consumers to:

- Focus on primary care, prevention, and wellness
- Actively manage chronic illness
- Use the least-cost, most appropriate care settings
- Use evidence-based, quality care

In its entirety, the Governor's Health Policy Agenda is designed to increase the State's ability to provide health care access to all Rhode Islanders. The following is a direct quote from his public announcement of this agenda[12]:

> "Affordable health care should be within reach for all Rhode Islanders, and our health care system should be responsive, efficient, and high quality. Yet trends suggest that Rhode Island is moving further, not closer, to these goals: health care costs are rising at more than three times the rate of inflation, and four times faster than wages. We ignore these trends at great risk to the health and future of our state, and the time to act is now.
>
> We need a common vision for our health care system—a system that focuses on health care as well as sick care, and that engages all Rhode Islanders. This system must put patients, not providers, at the center.
>
> This ideal drives our Administration's health care agenda and five near-term initiatives that will be the focus of the State's health care reform activities:
>
> - <u>The Wellness Initiative</u>
>
>  By 2010, we will:
>
>  - achieve the first "Well State" designation in the U.S. by the Wellness Councils of America (WELCOA), for having 20% of Rhode Island's workforce employed in WELCOA-certified "Well Workplaces"; and
>  - cut in half the number of Rhode Islanders with unhealthy and unsafe habits.
>
> - <u>Balanced Health Care Delivery System</u>

[12] Governor Carcieri. *November 15, 2005 Press Release*.

By 2010, we will have a health care system with more emphasis on primary care and a balanced deployment of hospital-based and specialty care resources.

- Anywhere, Anytime Health Information

By 2010, the majority of individuals in Rhode Island will have health information accessible electronically.

- Affordable Small Business Insurance

By 2010, we will increase by 10,000—or 15 percent—the number of small business employees enrolled in employer-sponsored health insurance.

- Smart Public Sector Purchasing

By 2010, we will reduce the rate of growth of the State's medical expenses by two percentage points, improve health plan performance, and use our contracts to drive changes in the health care delivery system.

These efforts address the underlying problems in the way we use, pay for, and deliver health care. Success will require collaboration, commitment, and time, and without a true spirit of public sector/private sector partnership, no meaningful progress can be made."

This agenda has been the guidepost for Pilot Project Planning Grant activities. During the initial period of this grant, the State:

- Completed the Rhode Island Employer Health Survey
- Completed the Rhode Island Employer Focus Group Analysis
- Prepared a legislative package to address the underlying problems discussed earlier and options deemed of greatest importance to the State

The legislative package – Rhode Island Health Care Affordability Act of 2006 – was enacted by the Rhode Island General Assembly and signed into law by Governor Carcieri, except for the bill involving subsidy for low-income individuals or firms employing low-income individuals. The components of the legislation that that did pass include the following:

- **H 7145 Substitute A – Coverage of Dependent Children** – This bill will extend the coverage on dependent children covered under group health insurance policies up to age 25, if the child is enrolled full- or part-time in a post-secondary educational institution. If that child is not, the insurer must offer the child a "conversion" policy. This legislation is designed to affect a population that tends to be uninsured.

- **H 7926 Substitute A – High Risk Pool (S 2264 Substitute A – High Risk Pool)** – This legislation amends the existing legislation on high risk pools to authorize the Office of the Health Insurance Commissioner (OHIC) to pursue Federal funding to develop a high risk pool for the individual market.

- **H 8243 – Transparency of Information on Health Care Quality and Cost (S 3170 – Substitute A)** – This bill requires OHIC to submit a report to the General Assembly by March 15, 2007 on proposed methods for insurers to "make facility-specific data and other medical service-specific data available" on cost and quality to facilitate consumers making informed choices on where to seek care

- **S 2107 Substitute A – Individual and Small Business Insurance** – This bill amends the individual health insurance statute to provide for reinsurance for individuals, but only for those individuals who "purchase the direct wellness health benefit plan". It also amends the small group insurance statute along the same lines but with the additional caveat that it only applies to small businesses that pay it least 50 percent of the single coverage premiums.

- **S 2848 Substitute A – Small Group and Individual Health Insurance** – This legislation amends the existing small group and individual insurance statutes principally by replacing the current language pertaining to "Standard and Economy Health Benefit Plans" with a "Wellness Benefit Plan". Unlike the benefit plans that it replaces, a Wellness Benefit Plan is not defined in statute but will be defined in regulation by OHIC. The plan needs to provide incentives for employers, providers, health plans, and consumers that:

    - Focus on primary care, prevention, and wellness
    - Actively manage the chronically ill population
    - Use the least cost, most appropriate setting
    - Use evidence based, quality care

  The "annualized individual premium rate" for the plan is targeted to be less than 10 percent of the "average statewide wage". The plan will need to be made available on or before May 1, 2007.

- **H8247 As Amended – Special Task Force on Health Care Reform -** This resolution would create a nineteen (19) member special task force whose purpose it would be to make a comprehensive study of the Massachusetts Health Care Reform Plan and its potential applicability to the State of Rhode Island, and who would report back to the General Assembly no later than June 5, 2007 and whose life would expire on August 5, 2007.

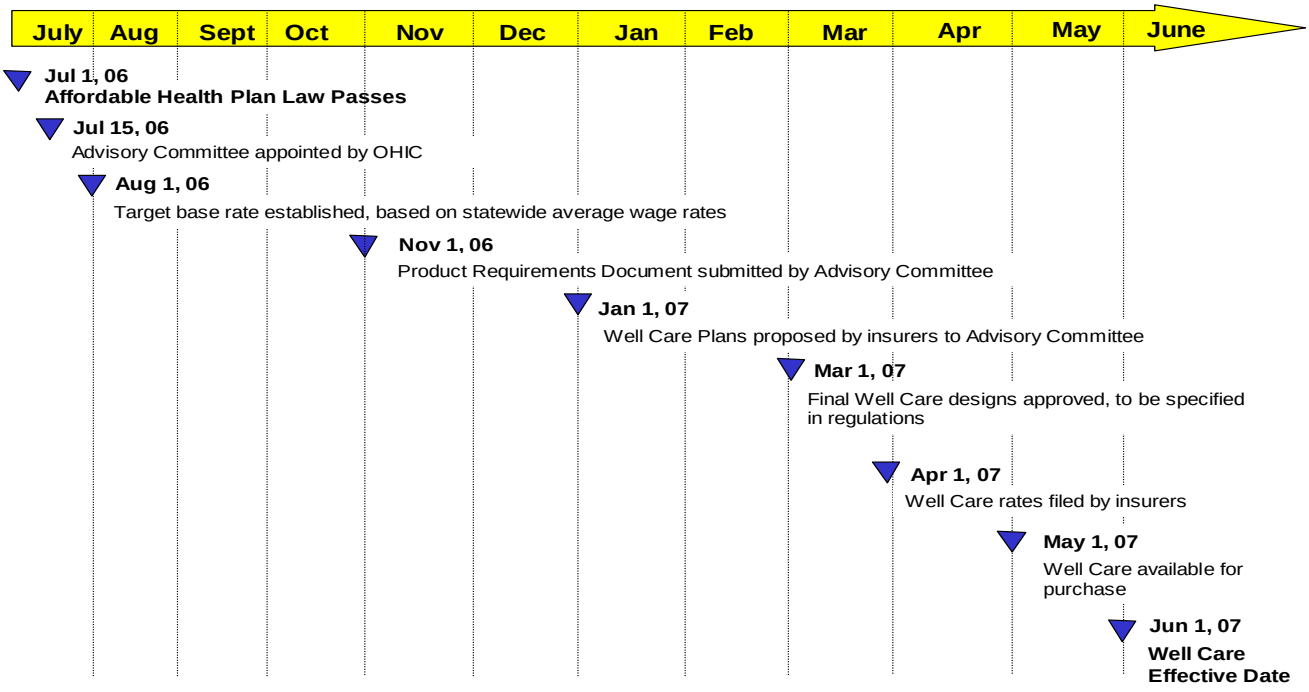
Appendix 2 provides an update of the project management matrix.

# D. IMPLEMENTATION STATUS

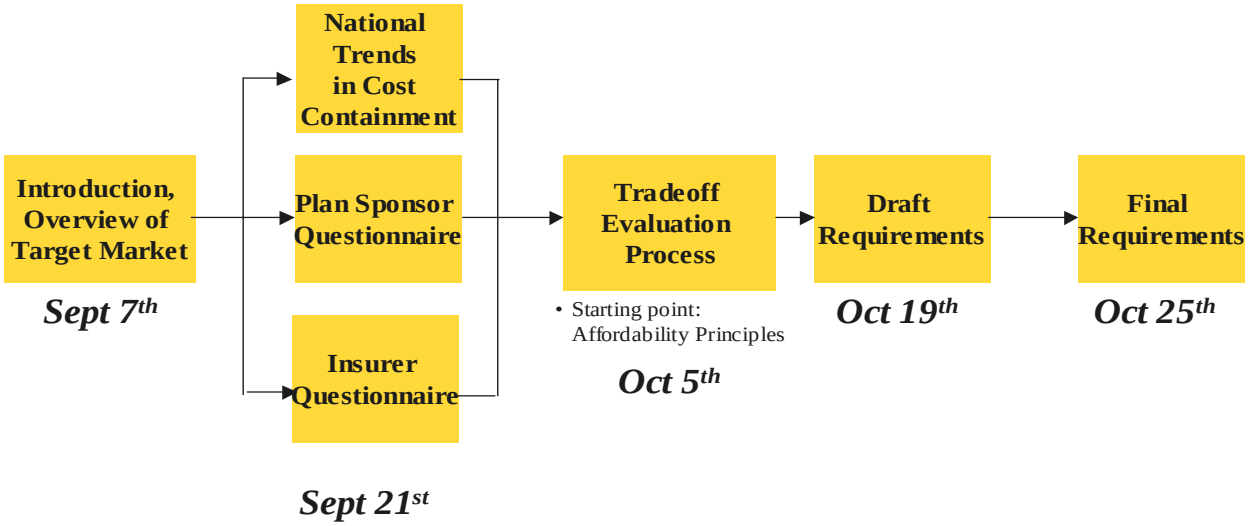
The legislation authorizing the Affordable Health Insurance reform proposal passed in July 2006. Since that time, the team has very quickly shifted focus, in part, toward implementation of the existing legislation. This implementation effort consists of three key components, each at very different stages of implementation:

5. **WellCare Product Design**
   The WellCare product is on a tight legislatively defined timeline – the product must be available for purchase by May 1, 2007, with an effective date of June 1, 2007. Implementation is underway, with the assistance of a benefits consultant – Boston Benefit Partners, who is under contract to facilitate the design process. Key elements of the implementation effort include the following:

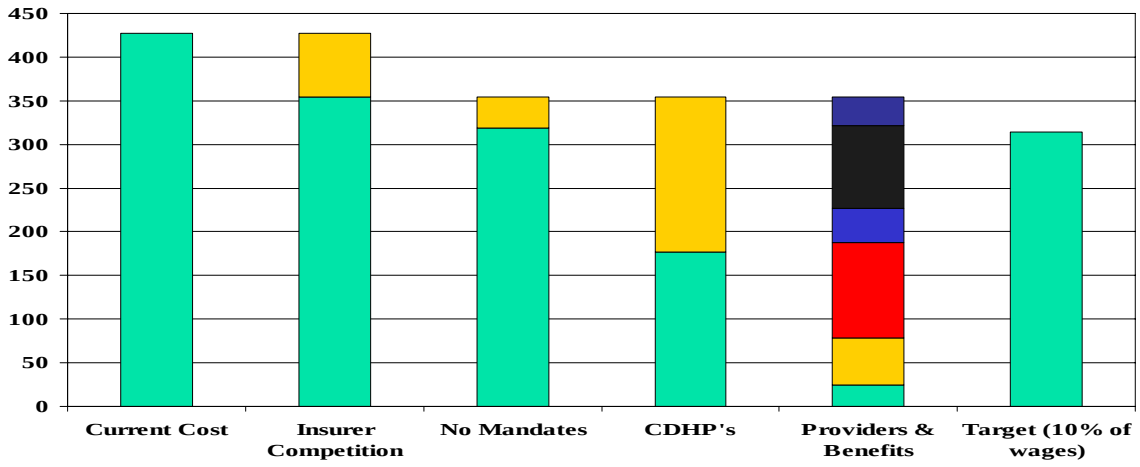
   - *The WellCare Advisory Committee* has been established, with meetings underway twice a month throughout the fall. Committee members include representatives of employers, health insurance brokers, local chambers of commerce, and consumers who pay directly for individual health insurance coverage.
   - *Key tasks* of this advisory committee include:
     - The Wellness Health Benefit Plan requirements document: This document must be disseminated to all Rhode Island small group and individual market health plans for responses by November 1st.
     - The WellCare product design: The health plans shall bring proposed plan designs to the committee for review on or before January 1, 2007.
   - The *timeline* for this committee is shown below:



- *Development Process*: The Advisory Committee meetings are facilitated by Boston Benefit Partners, who are engaging the committee in the following process:

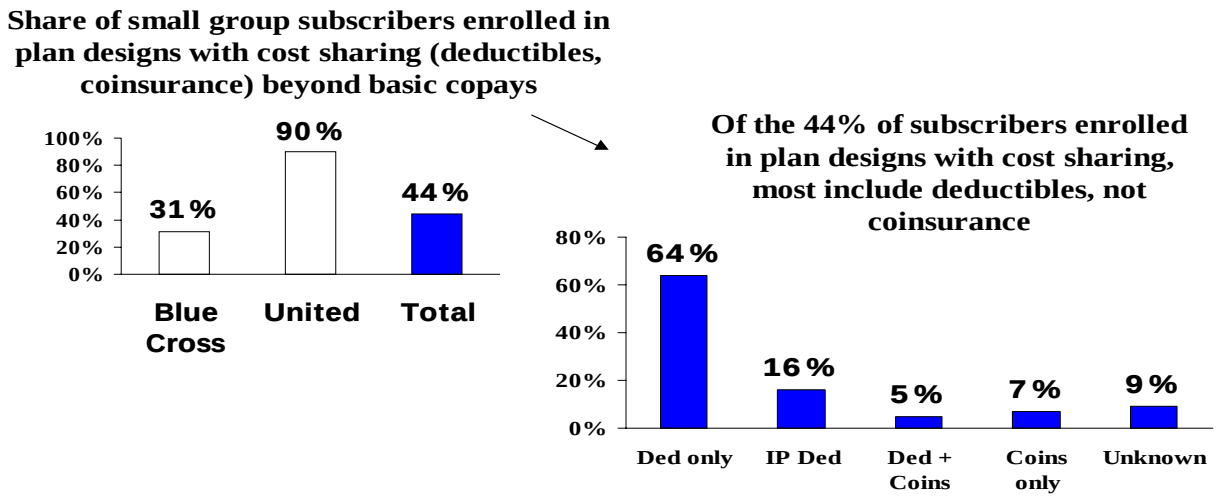



- *Key Challenges/Barriers to Implementation*:
  We have identified three key challenges to the successful implementation of the WellCare product:
  - *First, Affordability:* We need to recognize that there is no "silver bullet." So how do we design a product that is ~30% cheaper than the market norm. The following chart depicts this challenge graphically:



- *Second, limited toolkit:* We believe that there are four key tools that will allow us to reduce the cost of WellCare: Covered benefits, cost-sharing, provider networks, and other innovations. However, efforts to limit covered benefits are severely restricted by the state mandated benefit requirements. We had intended for this product to be exempt from state mandates, but that component of the legislation was rejected by the legislature. In addition, efforts to achieve cost savings through tiered/limited networks, though anticipated to be a critical component of this product, have a longer time horizon required for implementation than one year.

- *Third, Marketability:* Even if we are able to design an "affordable product" that reaches our price point, will anyone buy it? The WellCare product, given its aggressive price point, needs to include significant cost sharing – yet the Rhode Island market has historically been unusually slow/unwilling to adopt products with high cost sharing (see chart below) In addition, most studies suggest that in the absence of a state mandate, requiring people to purchase insurance, it will be difficult to significantly affect insurance take up.




Source: Market Conduct Study data and analysis, 2005.

- *Summary of Recommendations for Other States*:
  The legislation passed in July 2006 provided a good balance of the following three critical elements:
  - Public input through an Advisory Council of purchasers
  - Capped price point, as a percent of wages
  - Product and rate approval authority for OHIC

We believe that this combination will allow for effective implementation – and absent any one of these factors states would be less effective. In addition, we believe that take-up will likely be low in the first few years. States that would like to see more aggressive take up should consider enhancing our proposal with the following key elements:

- *State mandated benefit flexibility:* Without this flexibility, the "toolkit" available towards designing this more affordable product is significantly limited
- *Subsidy*: A subsidy program, targeting specific high risk subgroups, would significantly jumpstart the membership in this product and give insurers a "reason to play". Our legislation included a reinsurance subsidy, but was passed unfunded this year.
- *Individual mandate:* We recognize that this is a significant leap – only Massachusetts has taken this step so far. However, studies show that in a voluntary market it is difficult to affect insurance take-up. Any estimates of take up for a new program need to be tempered by this realization.

6. **WellCare Reinsurance Subsidy Program.**
The WellCare reinsurance program passed, unfunded, in July 2006 with a commitment by the legislature to explore additional funding sources this year. As such, short-term efforts are focused in two areas:

- *Identifying viable funding sources*
  We are considering a variety of possible sources, the most likely of which (currently) is some form of insurer-based tax, likely a hospital bed tax. We are in the process of contracting with a consultant to evaluate this option in more detail.
- *More detailed planning for the specific structure of the reinsurance program*.
  The legislation was purposefully vague in the specific structure of the reinsurance program – allowing for significant flexibility to be specified in regulations. As such, we are currently evaluating two options: (1) An aggregate risk-share arrangement, which would be MLR based; and (2) A specific reinsurance arrangement, a-la Healthy New York.

7. **Transparency**
By March 15, 2007 a report is due to the legislature on proposed methods for local insurers to make facility specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. As described above, this information would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care.

At this time, the following preliminary steps have been taken:

- The specific legislative language was added to the statutory list of items to be addressed by the Professional Provider Health Plan Workgroup, an existing workgroup under the responsibility of the Office of the Health Commissioner. This group has been meeting routinely since November 2005 to address identified issues between the local health plans and providers.

- The membership of the Workgroup varies based on the subject matter. When the group addresses the transparency legislation, additional representatives from the provider community will be included.
- The quality portion of this mandate will be addressed by the Department of Health (DOH) and be modeled after quality data measures currently in place for nursing homes and other providers. This information will be made available to the public.
- The Workgroup will be focusing primarily on making medical service cost specific information available to consumers and will discuss how to tie this to the quality data DOH is collecting.

The first meeting is to take place by the beginning of November 2006. The Workgroup will have a report for the legislature addressing this initiative by March 15, 2007.

## E. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

This section will be prepared as part of the Pilot Planning Grant project final report.

# APPENDIX 1

# SUMMARY OF POLICY OPTIONS

## Appendix 1

### F. Summary of Policy Options Considered by the State under the SPG Grant

| Option considered | Target Population | Estimated Number of People Served | Status of approval (for example waivers submitted or legislation proposed) Please provide month and year when waiver or legislation was proposed and if approved, month and year of approval | Status of implementation (please include month and year program or initiative began) | If implemented, most recent estimate within the federal fiscal year (Oct.1 – Sept 30) of number people served. Please provide the month and date of the point in time estimate provided. |
|---|---|---|---|---|---|
| Small Employer Market Legislation | Employees in firms under 50 | 360,000 | Legislation passed June 2006 | Implementation planned for 2007 | To be determined |
| Wellcare market subsidy | Uninsured adults (18-64) under 300% FPL | 72,926 | Legislation passed June 2006 but no funding approved. Will need to | Fall 07 if passed | To be determined |

**APPENDIX 2**

**PROJECT MANAGEMENT MATRIX**

## F. Project Management Matrix

# HRSA 2006-2007

| Project Management Matrix Task/Action Step | Timetable 9/1/06-8/31/07 | Organization/Person Responsible | Anticipated Results |
|---|---|---|---|
| HRSA Grant Phase 2 & 3: Tasks 1, 2, 3 | | | |
| Task 1: The Access Work Group of the Governor's Health Care Cabinet will continue to serve as the steering committee for the Rhode Island HRSA State Planning Grant - Phase 2 and Phase 3. The Project Management Team for the HRSA grant will provide staff support to the Work Group. | | | |
| Action Step 1.1- The Health Care Cabinet will continue its charge to the Access Work Group. | September 2006-August 2007 | Amy Lapierre, Deb Faulkner | Increase in number of quality, affordable insurance options for small businesses. |
| Action Step 1.2 - The Access Work Group will develop recommendations to the Health Care Cabinet by June 30, 2006 | September 2005-June 2006 | Deb Faulkner | • Development of an affordable health insurance product<br>• Increased number of working families enrolling in ESI<br>• Increased number of working families switching from RIte Care to RIte Share |
| Action Step 1.3 - The HRSA State Planning Grant Project Management Team will conduct the activities of the HRSA grant Phase 2 and Phase 3 | Sep 2006 to Aug 2007 | Amy Lapierre | • Address objectives of Access Work Group.<br>• Prepare a report to the Cabinet& USDHHS. |
| Task 2: Design an affordable health insurance product that is (a) attractive to small-employers, employees, self-employed and individuals, (b) offered by private insurers and (c) not threatened by adverse selection | | | |
| Action Step 2.1- Continue to design a potential new state-sponsored insurance product | September 2006- May 2007 | Deb Faulkner | Affordable health care product designed |
| Action Step 2.2- Continue develop eligibility, cost and benefit design | Sep 2006 to March 2005 | Deb Faulkner | Eligibility and cost model designed |
| Action Step 2.3- Continue to work with stakeholders | Sep 2006 to August 2007 | Deb Faulkner | Stakeholders support affordable product/price and eligibility |
| Task 3: Build sufficient support within the business community to assure a critical mass of employers and their employees will purchase health care coverage during the pilot phase of the project | | | |
| Action Step 3.1 - Develop a partnership between the Rhode Island business community and the State government. | Sep 2006 to August 2007 | Deb Faulkner, Matt Stark, Chris Koller | Informational meetings held with key informants. |
| Action Step 3.2 - Develop a fact sheet (or series of fact sheets) with details on the cost-to-business of the current health care situation in Rhode Island and disseminate within the business community | July 2006 | JSI | Individualized fact sheet(s) developed as part of Employer Report. |

| Project Management Matrix Task/Action Step | Timetable 9/1/06-8/31/07 | Organization/Person Responsible | Anticipated Results |
|---|---|---|---|
| Action Step 3.3 - Hold regular meetings with the Working Committee and get their active involvement in the issues, goals, compromises, design, and marketing plans for this health care insurance product | Sep 2006 to August 2007 | Deb Faulkner | Gain input required to balance costs with coverage. |
| Action Step 3.4 - Form a high-level Business Group on Health | Sep 2006 to August 2007 | Chris Koller | • Policy recommendations developed.<br>• Raised public awareness and support. |
| HRSA Pilot Planning Grant Phase 3 only: Tasks 4, 5 and 6 | | | |
| Task 4. Collaborate with the Rite Care program in current efforts to develop Rhode Island's primary care infrastructure so it has the capacity to meet the demand for primary care 24 hours a day, seven days a week. | | | |
| Action Step 4.1 – Members of the Project Management Team will participate in the RIte Care Initiative entitled "Appropriate Care / Appropriate Settings" and collaborate with the RIte Care program to determine how to apply the principles of this initiative to an affordable health care product for small business | July 2006-June 2007 | Deb Florio, Melinda Thomas, Amy Lapierre | RIte Care Health Plan contractual agreements will offer financial incentives for targeted efforts to reduce emergency department use through member education and provider capacity development. |
| Action Step 4.2 - Continue to Collaborate with Quality Partners of Rhode Island on the "Open Access Collaborative" begun in April 2005 | Sep 2005 to June 2006 | Johanna Bell | Support the DHS's goal of expanding access to primary care services and insuring access to highest quality care at the most appropriate location. |
| Action Step 4.3 -Develop and Implement a plan to analyze the Open Access Collaborative | June 2006 | Deirdre Gifford, MD | • Control clinics, data sources and variables identified and analytic plan developed.<br>• Data collection instruments developed and tested.<br>• Preliminary descriptive data collected. |
| Action Step 4.4 - Two relevant reports will be produced by Quality Partners prior to inform the Primary Care Initiative | August 2005 | Task deleted | Report on Effective Means for Reducing ED Utilization and Update on RI Emergency Department Utilization Data developed |
| Action Step 4.5 - Develop, implement and host a "Policy Summit on Reducing Emergency Department Utilization for Non-Emergent Care in Rhode Island." | September 2006- August 2007 | Task deleted | Convened Primary Care Stakeholders group to develop strategies to reduce emergency department utilization. |

| Project Management Matrix Task/Action Step | Timetable 9/1/06-8/31/07 | Organization/Person Responsible | Anticipated Results |
|---|---|---|---|
| Action Step 4.6 - Conduct Analysis of Open Access Scheduling program in Rhode Island | September 2006 – August 2007 | Deirdre Gifford, MD | Development of a proposed set of quality metrics for appropriate primary care access and ED utilization. |
| Task 5. Recommend the development of public and/or private purchasing entity to design and administer a voluntary market-based health plan to help small employers, the self-employed and individuals afford health care coverage | | | |
| Action Step 5.1 – Explore optional organizational configurations for a health care purchasing entity for small employers | September 2006-March 2007 | Deb Faulkner | Options assessed. |
| Action Step 5.2– Recommend organizational structure and function of a purchasing entity | March 2007 | Deb Faulkner | Recommendation developed on functions, agencies, staffing, eligibility, and public reporting of purchasing entity. |
| Task 6. Prepare a request-for-proposals to be issued by the purchasing entity requesting bids to offer an affordable health care product. | | | |
| Action Step 6.1- draft RFP prepared for review | December 2006 | Deb Faulkner | Will accomplish through regulations and statute rather than RFP |
| Action Step 6.2 RFP finalized and submitted to Health Care Cabinet | January 20007 | Deb Faulkner | Will accomplish through regulations and statute rather than RFP |
| HRSA Grant Phase 2 and 3: Task 7 | | | |
| Task 7. Prepare a final report on project activities to be submitted to the Governor's Health Care Cabinet, the Joint Legislative Oversight Committee on Health Care and the U.S. Department of Health and Human Services | | | |
| Action Step 7.1- Final Report submitted | September 2007 | Amy Lapierre, Melinda Thomas | Report submitted. |

# APPENDIX 3

# REPORTS

## H. APPENDIX 3

## Legislation

- **H 7145 Substitute A – Coverage of Dependent Children**

- **H 7926 Substitute A – High Risk Pool (S 2264 Substitute A – High Risk Pool).**
- **H 8243 – Transparency of Information on Health Care Quality and Cost (S 3170 – Substitute A)**
- **S 2107 Substitute A – Individual and Small Business Insurance**
- **S 2848 Substitute A – Small Group and Individual Health Insurance**
- **H 8247 As Amended – Special Task Force on Health Care Reform**

## Reports

- **Employer Survey completed by JSI**
- **RIte Share Employer Survey completed by JSI**